

STUDENT HEALTH UPDATE  
2008-2009 SCHOOL YEAR

PARENT(S)/GUARDIAN(S), please complete this information sheet. Parent(s)/Guardian(s) make sure your signature is included on the form.

STUDENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

LEGAL GUARDIAN: \_\_\_\_\_

GRADE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

ALLERGIES TO MEDICATION: \_\_\_\_\_

PARENT/GUARDIAN ADDRESS: \_\_\_\_\_

PHONE NUMBERS WHERE PARENT/GUARDIAN MAY BE REACHED: Please include all cell phone numbers and pagers.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

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The school needs permission forms signed by you and your child's doctor for all medication that is given at school. The permission forms may be obtained from the school office. There is also a form for non-prescription medicine in the office. Medication will not be given without these signed forms. Schools do not provide medication for students.

Is your child currently (within the last twelve months) being treated for any of the following conditions? If you circle yes, this means a doctor has diagnosed the problem.

Diabetes yes or no If yes, what medication does your child take? \_\_\_\_\_

Asthma yes or no If yes, what medication does your child take? \_\_\_\_\_

Seizures yes or no If yes, what medication does your child take? \_\_\_\_\_

Sickle Cell yes or no If yes, what medication does your child take? \_\_\_\_\_

Heart Problems yes or no If yes, what medication does your child take? \_\_\_\_\_

Headaches yes or no If yes, what medication does your child take? \_\_\_\_\_

Allergies yes or no If yes, what medication does your child take and what is your child allergic to? \_\_\_\_\_

Vision Problems yes or no If yes, does your child wear glasses or contacts? \_\_\_\_\_

Hearing Problems yes or no If yes, does your child wear a hearing or need assistance with hearing? \_\_\_\_\_

Family doctor: Name \_\_\_\_\_

Family doctor: Address: \_\_\_\_\_ Phone: \_\_\_\_\_

SIGNATURE OF PARENT GUARDIAN: \_\_\_\_\_

Please complete information on back of this form

I give permission for my child, \_\_\_\_\_, to participate in the mass screening procedures for vision, hearing, speech, dental, and scoliosis, as well as any individual screening of the above deemed necessary while enrolled in Abbeville County School district.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

I, the undersigned, do hereby authorize officials of Abbeville County School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be necessary in an emergency, for the health of the child.

In the event physicians named on this form or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

**Child's Name:** Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

**Preferred Physician:** \_\_\_\_\_ Telephone: \_\_\_\_\_